ORDER OF THE CHIEF,
NATIONAL GUARD BUREAU

ANGI 36-103
5 JUNE 1998

Personnel

SUICIDE PREVENTION PROGRAM

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

This instruction outlines policy and guidance for preventing suicides in the Air National Guard (ANG), and further defines various Air Force (AF) suicide prevention directives for application to the ANG. This instruction applies to all ANG members not on Extended Active Duty. This instruction interfaces with AF 36 (Personnel) and 44 (Medical) series publications. Send comments and suggested improvements, through channels, to ANG/SG, 3500 Fetchet Avenue, Andrews AFB MD 20762-5157.

SUMMARY OF CHANGES: This is the initial publication of ANGI 36-103.

1. Background.

1.1. References, Abbreviations, and Acronyms used in this instruction are listed in Attachment 1.
1.2. Due to an upward trend in AF suicide rates since 1980, AF/CV established an integrated product team (IPT) to evaluate the problem and recommend prevention-based corrective strategies. The IPT recommended actions to combat Air Force suicides on two fronts. First, we must mitigate risk factors, including legal, mental health, substance abuse, and relationship problems. Second, we have to strengthen protective factors, such as social support, coping skills, and establishing a culture that encourages help-seeking behavior. The ANG was part of the multidisciplinary Total Force Team, and the directives outlined in this instruction are based on the IPT's recommendations.

OPR: ANG/SGPB (Maj Hall) Certified by: NGB/CF (Col W. Foulois)
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1.3. While ANG suicide rates have been stable, nearly a hundred citizen-airmen took their own lives between 1992 and 1997. Suicide is currently the second leading cause of death among Air Guard members. Each event signifies a needless, preventable tragedy that causes the loss of a valued citizen, warrior, and member of our Guard Family. In protecting our people, the ANG must be a concerned, caring, and responsible community where individuals are motivated to seek help with personal struggles, and can do so without fear of being "labeled". In the ANG, we take care of our own. Each of us must be poised to recognize the early warning signs of those in need, and know where and how to get help.

2. Responsibilities.

2.1. NGB/CF establishes and emphasizes the ANG Suicide Prevention Program.
2.2. ANG/SG oversees and coordinates the ANG Suicide Prevention Program. Oversees Level 1 Training, see Attachment 2; updates related policy and guidance, including The *ANG Suicide Prevention "Link"--Buddy Care Basics* Brochure, see Attachment 3. Reports aggregate Levels 1 and 2 Training compliance statistics to AF/SG. Requests suicide event data of responsible agencies, as required.
2.3. ANG/HC oversees Level 2 Training, see Attachment 4; updates related policy and guidance, including The *Suicide Prevention and Intervention Guide for Commanders and First Sergeants* Brochure, see Attachment 5. Forwards aggregate Level 2 Training statistics to ANG/SG. Arranges for Level 3, as well as NGB and ANGRC, Training.
2.4. NGB/PA periodically publishes suicide prevention-based articles in media disseminated ANG-wide, and helps unit PA offices publish same.
2.5. PMEC/ANG, and the First Sergeant Academy, incorporate suicide prevention education in appropriate education and training curricula, see Attachment 6, "Military Education and Training."
2.6. Unit Commanders provide a safe, healthful, and caring environment for their ANG community, including separated units. Ensure implementation of unit-level suicide prevention initiatives, and appropriate emphasis.
2.7. Unit First Sergeants assist commanders in implementing and emphasizing the unit suicide prevention program.
2.8. Medical Units administer Level 1 Training (Attachment 2), track compliance, and report to ANG/SG.
2.9. Unit Chaplains administer Level 2 Training (Attachment 4), track compliance, and report to ANG/HC.
2.10. Unit Public Affairs partner with helping agencies in disseminating suicide prevention information.
2.11. Supervisors ensure subordinates receive required training. Provide a supportive, caring work environment. Help those in need gain access to helping resources.
2.12. Unit members receive required training, and embrace responsibilities toward fellow Air Guard men and women under the buddy care concept.

3. Activities.

The ANG's suicide prevention strategy includes the following nine initiatives. Supplemental guidance is provided in attachments and parent AF directives.
3.1 Suicide Prevention Awareness Training. Suicide can be prevented, but for this to happen, ANG members must be aware of the warning signs for those at risk, the helping resources

available, and the actions they should either take or avoid. ANG suicide prevention training will accommodate three levels of responsibility.

3.1.1 Focusing on the buddy care concept, Level 1 Training (Attachment 2) is provided for all ANG members (supervisory and nonsupervisory personnel) on an annual basis by the unit's medical squadron (MDS). It is administered through distribution of the *ANG Suicide Prevention "Link"--Buddy Care Basics* Brochure (Attachment 3) in conjunction with the annual influenza immunization program.

3.1.2. In Level 2 Training (Attachment 4), Unit Chaplains (HC) educate commanders and first sergeants, focusing on their critical roles as "unit gatekeepers". It is designed to provide these senior leaders with initial and annual refresher training in: (1) identification and referral of at-risk personnel (2) squadron-level risk management programs (3) managing organizational stress.

3.1.3. Level 3 Training is provided periodically to senior field leaders during the Senior Commanders Conference, Air Directorate Field Advisory Council, Enlisted Field Advisory Council, and other appropriate fora. This training is based on the Level 2 curriculum. ANG/HC arranges for Level 3 Training.

3.1.4. Metrics (see Attachments 2 and 4) will be maintained for Levels 1 and 2 Training only. Each unit MDS and HC must submit annual training compliance reports to ANG/SG and ANG/HC, respectively.

3.1.5. Detailed guidance is provided in Attachments 2, 4, and 7. This augments AFI 44-154, *Education and Community Training.*

3.2 Military Education and Training. The Air Force incorporated suicide prevention education into all levels of Professional Military Education (PME) for Air Force officers and enlisted, to include Air Guard members. Additionally, the ANG PME Center (PMEC) will incorporate suicide prevention education into appropriate military education and training curricula. These courses will include, at the minimum: Academy of Military Science (AMS); Commander's Seminar; National Guard Supervisor Development Course; and Chaplain's Trauma Course. As well, the ANG First Sergeant Academy (Maxwell AFB) will incorporate suicide prevention education into its curriculum. Curricula for the ANG PMEC and First Sergeant Academy will focus on buddy care and leadership roles in suicide prevention. Added guidance is provided in Attachment 6.

3.3 Critical Incident Stress Management (CISM). Unit commanders must familiarize themselves with the guidance outlined in AFI 44-153, *Critical Incident Stress Management.* This AFI provides for professional teams to aid commanders in assisting ANG members affected by traumatic events. It also allows for integration of ANG helping professionals into Air Force CISM teams, when feasible.

3.4 Mortality Surveillance. ANG Manpower Personnel Flights (MPF) must report all deaths, to include suicides, IAW AFI 36-3002, *Casualty Services*. Upon receipt, the unit manpower personnel (MP) section will send death certificates to HQ ARPC/DRSE, who in turn, forwards a copy of the data to Office of Prevention and Health Services Assessment (OPHSA), by specified agreement. ***NOTE:*** OPHSA conducts ongoing Total Force mortality surveillance, and epidemiological analyses of ANG data can be requested through ANG/SG.

3.5 Investigative Interview Policy. A study of AF suicides indicated that many suicide victims were under legal investigation; the most critical period was determined to be immediately following the initial investigative interview. Chief of Staff of the Air Force (CSAF) issued a policy memorandum (Attachment 8) mandating that all Air Force members be "handed off" to the unit commander, first sergeant, or the supervisor, as appropriate, following investigative interviews.

3.6 Limited Privilege. This initiative is designed to identify and help those members who, because of the stress of impending disciplinary and/or administrative actions, pose a genuine threat of

suicide. Under limited privilege, ANG members will be granted limited protection with regard to information revealed in, or generated by, their clinical relationship with mental health providers. Attachment 9 elaborates.

3.7 Integrated Delivery System (IDS). Base helping agencies often operate independently in providing services for common sources of human problems, such as relationship, financial, job performance, legal, substance abuse, and mental health concerns. Under the IDS concept, ANG chaplains, health promotion managers and other medics, as well as family support personnel (during activation) must seek opportunities to partner in delivering needed services to individuals and units. Agencies in the local civilian community should also be considered, as appropriate. Success hinges upon open communication, collaborative planning, and cooperative delivery of programs and services. At least annually, ANG helping agencies must collectively consider the needs of the base community, weigh their resources and capabilities, and plan for the most efficient and effective methods to deliver prevention-based programs and services. The base Health Promotion Working Group provides a suitable forum. Implementation is at the discretion of the individual base to allow maximum flexibility in meeting local needs based on local requirements and resources.

3.8 Public Affairs (PA) Initiatives. In coordination with NGB/PA, unit PA offices will partner with base, community, and higher headquarters chaplains, medics, and other helping personnel to disseminate suicide prevention information. At least annually, unit PAs will field a feature suicide prevention-related article; subject matter might include stress management/coping skills, relationships, or other appropriate topics. The article should be for general dissemination in the unit publication or other suitable medium ; i.e., newspaper, newsletter, Local Area Network (LAN) bulletin board, etc. Similarly, NGB/PA periodically publishes articles in media disseminated ANG-wide.

3.9 Suicide Prevention at the NGB and ANG Readiness Center (ANGRC). National Guard Bureau (NGB) and ANGRC directors and supervisors must remain aware of workplace climate and worker needs, and take necessary actions to maintain a safe, healthful, and caring environment. However, it is essential that every member of the NGB and ANGRC staffs be able to identify coworkers having difficulty coping with life events and refer them to help. To that end, and in coordination with the 89 MDG, 201 MSS and NGB/CF, ANG/HC will:

- Arrange for Level 1 Training for all assigned NGB and ANGRC personnel during commander's calls or other fora.
- Arrange for Level 2 Training for senior NGB and ANGRC leaders during the Leadership Focus or other fora.

Attachments 2-7 provide the backdrop for this initiative.

PAUL A. WEAVER, JR.
Major General, USAF
Director, Air National Guard

OFFICIAL

DEBORAH GILMORE
Chief
Administrative Services

Attachment 1

Glossary of References, Abbreviations, and Acronyms

References:

AETC Pam 44-101	*Suicide Prevention LINK--Buddy Care Basics*
AETC Pam 44-105	*Suicide Prevention LINK--A Pocket Guide for Commanders, First Sergeants, and Supervisors*
AFI 36-3002	*Casualty Services*
AFI 44-109	*Mental Health and Military Law*
AFI 44-153	*Critical Incident Stress Management*
AFI 44-154	*Education and Community Training*

ANG Suicide Prevention "LINK"--Buddy Care Basics Brochure
CSAF Message on Air Force Suicide Prevention (DTG 151937Z OCT 96)
CSAF Policy for Investigative Interviews dated 4 Dec 96
Suicide Prevention and Intervention Guide for Commanders and First Sergeants Brochure

Abbreviations and Acronyms:

AF	Air Force
AFMOA	Air Force Medical Operations Agency
AMS	Academy of Military Science
ANG	Air National Guard
ANGRC	Air National Guard Readiness Center
CISM	Critical Incident Stress Management
CSAF	Chief of Staff of the Air Force
DTG	Date-Time Group
HC	Chaplains
IDS	Integrated Delivery System
IPT	Integrated Product Team
LAN	Local Area Network
LPSP	Limited Privilege Suicide Prevention
MDS	Medical Squadron
MP	Manpower Personnel
MPF	Manpower Personnel Flight
NGB	National Guard Bureau
OPHSA	Office for Prevention and Health Services Assessment
OPR	Office of Primary Responsibility
PA	Public Affairs
PME	Professional Military Education
PMEC	Professional Military Education Center (McGhee-Tyson ANGB)
POC	Point of Contact
SG	Medical/Surgeon
UCMJ	Uniform Code of Military Justice

Attachment 2

Implementation Guidelines for Level 1 Suicide Prevention Awareness Training

A2.1. Purpose. This attachment outlines policy and guidance for medical squadrons (MDS) in implementing Level 1 Suicide Prevention Awareness Training at ANG bases. It supplements AFI 44-154, *Education and Community Training*. ANG/SG is OPR for this attachment.
A2.2. Policy.
A2.2.1. All ANG personnel receive annual suicide prevention awareness training, refer to *ANG Suicide Prevention "Link"--Buddy Care Basics* Brochure .
A2.2.2. Training is mandatory for all Air Guardsmen, and should be made available to state employees.
A2.2.3. Training consists of person-to-person distribution of the attached brochure, *ANG Suicide Prevention LINK-Buddy Care Basics*, during the annual influenza immunization program.
A2.2.4. ANG medical squadrons are the OPRs for Level 1 Suicide Prevention Awareness Training, including training delivery, compliance tracking, and annual metrics reporting to ANG/SG.
A2.2.5 Metrics include number and percent of personnel (mandated only) trained annually.
A2.2.6 ANG/SG is responsible for ANG suicide prevention policy and guidance, including updates to The *ANG Suicide Prevention "Link"--Buddy Care Basics* Brochure, and forwarding collated ANG metrics to higher headquarters.
A2.3. Procedures/Guidance.
A2.3.1. MDSs provide annual Level 1 Training in conjunction with the yearly influenza immunization program (beginning CY97).
A2.3.2. MDS immunization teams furnish each recipient of the flu vaccine with a copy of the subject brochure. Brochure file may be downloaded from the ANG Biomedical Sciences Home Page and reproduced locally. (Navigate from the ANG Home Page at http//:www.ang.af.mil/)
A2.3.3. MDSs collaborate with the base civilian personnel agency to make The *ANG Suicide Prevention "Link"--Buddy Care Basics* Brochure available to state (i.e., strictly civilian) employees. MDSs are responsible for providing the local civilian personnel agency with The *ANG Suicide Prevention "Link"--Buddy Care Basics* Brochure or copy of the text file; they are not responsible for dissemination to state employees, except by local agreement.
A2.3.4. MDSs continue to report annual influenza immunization compliance to ANG/SG by 15 April each year, and in so doing satisfy the annual suicide prevention awareness training compliance metric. ANG/SG reports aggregate Level 1 metric data (with Level 2 data, see Attachment 4) to the AFMOA Suicide Prevention POC by NLT 1 May of each year.
A2.3.5. MDSs may add to, but not detract from, the content of the attached *ANG Suicide Prevention "Link"--Buddy Care Basics* Brochure. The brochure may be "personalized" for local use.
A2.3.6. Based on local needs and circumstances, MDSs are encouraged to collaborate with other base-level helping agencies (e.g., chaplains, family support, etc), as well as higher headquartered agencies, to develop and implement additional suicide prevention training to augment *Buddy Care Basics*

Attachment 3

ANG SUICIDE PREVENTION "LINK"--Buddy Care Basics

Look for possible concerns
Inquire about concerns
Note level of risk
Know referral resources and strategies

_____

LIFE EVENTS INTERVENTION—YOU can make a difference!

Suicide can be prevented, but for this to happen, an environment of concern and 'buddy care" must develop to a point where no one has to "go it alone". We must create a "web" that extends to every individual, and links individuals, supervisors, first sergeants, commanders, the community, and the medical professionals in circles of concern.

Helping agents can't help if they are not aware of the need. The majority of those who committed suicide in the Air Force in the past 10 years were not known to the medical community; yet, they gave warning signals. The best resource to turn this problem around is the powerful concept of 'buddy care." Buddies can help friends and coworkers in their time of need by "linking" them to helping resources.

This is what the ANG LINK is all about, and it must start with each of us choosing to make a difference through life events intervention. This material was prepared to help you begin this process.

BE AWARE OF THE FACTS

1. Suicide is preventable. Most suicidal persons want to live; they are just unable to see alternatives to their problems. They often view their situation as HOPELESS.
2. Most often, suicidal persons are temporarily overwhelmed with real LIFE EVENTS. Some of the most commonly experienced are relationship difficulties, separation, divorce, financial problems, pending legal actions, work problems, loss of a loved one, illness, etc.
3. Most suicidal persons give definite WARNINGS of their suicidal intentions, but we are often unaware of their significance or do not know how to respond.
4. Suicide cuts across all ranks, ages, and economic, social, religious, and ethnic boundaries.
5. Suicide is the eighth leading cause of death in the US and the third leading cause among 15-24 year-olds, behind accidents and homicide.
6. Males suicide rates and numbers are 3 to 4 times those for females. While there are no official US statistics on attempts, it is estimated there are 8-20 attempts for each death by suicide. Females make 3 to 4 times as many attempts as males.
7. Feelings of HOPELESSNESS (e.g., "there are no solutions to my problems") are more predictive of suicide than diagnosed depression.
8. The SOCIALLY ISOLATED are at higher risk for suicide.
9. Suicide intimately affects at least six other people.

10. Those with a behavioral or mental health diagnosis are generally associated with higher risk of suicide. At particular risk are the depressed, schizophrenics, alcoholics, and panic disorder sufferers.
11. There are 30,000+ suicides annually nationwide (83 per day, one every 17 minutes), with 12 of every 100,000 Americans killing themselves.
12. Suicide accounted for 13 percent of all ANG deaths between 1990 and 1995; on average, 13 Air Guardsmen die by suicide each year.

BE AWARE OF THE WARNING SIGNS

There is no "typical" suicidal person, but there are some common warning signs. When you act on these warning signs, you can save a life.

A suicidal person may:

- Talk about committing suicide
- Have trouble eating or sleeping
- Experience drastic changes in behavior
- Withdraw from friends or social activities
- Lose interest in hobbies, work, school, etc.
- Make final arrangements, prepare for death
- Give away prized possessions
- Have attempted suicide before
- Take unnecessary risks
- Have had a recent or severe loss
- Be preoccupied with death and dying
- Lose interest in his/her personal appearance
- Increase his or her use of alcohol or drugs

BE AWARE OF FEELINGS

Many people contemplate suicide at some point in their lives. Most decide to live, realizing the crisis is temporary and death isn't. Still, people having a crisis may see their situation as inescapable and sense hopelessness and loss of control. Commonly experienced feelings are:

- Can't stop the pain
- Can't think clearly
- Can't make decisions
- Can't see any way out
- Can't sleep, eat, or work
- Can't get out of depression
- Can't make the sadness go away
- Can't see a future without pain
- Can't see themselves as worthwhile
- Can't get someone's attention
- Can't seem to get control

BUDDY CARE DOs AND DON'Ts

- Do be aware. Learn the warning signs.
- Do get involved. Become available. Show interest and support.
- Do ask if they are thinking about suicide.
- Do talk openly. Be direct. Determine if they have a suicide plan.
- Do question accessibility to guns, pills, etc.
- Do listen. Allow expression of feelings.
- Do offer empathy, not sympathy.
- Don't lecture or debate—try not to judge.
- Don't dare them to do it.
- Don't give advice.
- Don't blow them off as not being serious—take all threats seriously.

- Don't act shocked. This will put distance between them and you.
- Don't be sworn to secrecy. Seek support.
- Do offer hope that alternatives are available.
- Do take action. Remove means, if possible.
- Don't leave the person alone--Get help now!
- During duty hours, notify your supervisor of the person you are concerned about.
- After duty hours, contact the hospital emergency room, 911, or police.

It's not your job to evaluate the person; it's your job to INFORM "helping resource" personnel when you are concerned about possible risk.

WHO ARE THE "HELPING RESOURCES"?

- Supervisors, First Sergeants, Commanders
- Chaplains
- Mental Health Professionals
- Security or Local Police
- Family Support/Advocacy Centers
- Legal Professionals
- 911, Hospital ER, Fire Department

Brochure OPR: ANG/SG (1 Feb 98 version)
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To create single page document, print in "landscape", front-to-back format
Document may be "personalized" for local unit use and reproduced locally

Attachment 4

Implementation Guidelines for Level 2 Suicide Prevention Awareness Training

A4.1. Purpose. This attachment outlines policy and guidance for chaplain sections (HC) in implementing Level 2 Suicide Prevention Awareness Training for "unit gatekeepers" at ANG bases. It supplements AFI 44-154, *Education and Community Training*. AFI 44-154 outlines the specifics of suicide prevention training in the Air Force. ANG wing (or senior) chaplains are identified by the ANG as the trainers for unit gatekeepers, which ANG/HC and ANG/SG have designated as "Commanders" and "First Sergeants" as identified by unit MPFs (cf. PAS Codes). ANG/HC is OPR for this attachment.

A4.2. Policy. Each unit ANG/HC will conduct annual training of First Sergeants and Commanders in suicide prevention awareness. The purpose of this training is to equip squadron supervisory personnel to act as gatekeepers, lowering the barriers to self-referral and destigmatizing help-seeking behavior through changing the corporate culture.

A4.3. Procedures/Guidance.

A4.3.1. The Wing (or Senior) Chaplain will provide Suicide Prevention Awareness Training to all First Sergeants and Commanders, as identified by the local MPF.

A4.3.2. Copies of *Suicide Prevention and Intervention Guide for Commanders and First Sergeants* (brochure) will be reproduced locally and distributed to each person receiving training.

A4.3.3. The training will, as a minimum, cover the curriculum as contained in the booklet in (2) above, but the format of the local presentation will be at the discretion of the Wing (or Senior) chaplain.

A4.3.4. Local variations, which might include reference to local unit or community events, are authorized.

A4.3.5. The local HC office will maintain a roster of the individual personnel who have been so trained.

A4.3.6. NLT 1 April of each year, each unit HC office will verify in writing to ANG/HC the following:

A4.3.6.1. Number of First Sergeants serviced by local MPF

A4.3.6.2. Number of Commanders serviced by local MPF ***NOTE:*** (6.1) and (6.2) should be verified in the report by an MPF official]

A4.3.6.3. Number of First Sergeants who received training in that year

A4.3.6.4. Number of Commanders who received training in that year

A4.3.6.5. A brief description of the format, dates offered, and length of the training classes

A4.3.7. NLT 15 April of each year, ANG/HC will forward aggregate Level 2 Training metric data to ANG/SG. ANG/SG reports the data (with Level 1 Training metric data, see Attachment 2) to the AFMOA Suicide Prevention POC by NLT 1 May of each year.

Attachment 5

SUICIDE PREVENTION AND INTERVENTION GUIDE FOR COMMANDERS AND FIRST SERGEANTS

ANG SUICIDE PREVENTION *"LINK"*

Look for possible concerns
Inquire about concerns
Note level of concern
Know referral resources and strategies

SUICIDE PREVENTION & INTERVENTION GUIDE FOR COMMANDERS & FIRST SHIRTS

Suicide accounted for 13 percent of all ANG deaths between 1990 and 1997. On average, 13 Air Guardsmen die by suicide each year. Each suicide intimately affects at least six other people. Suicide is not only a tragic loss of life, but it is disruptive to the surviving members of the military community. It can also have a direct impact on mission sustainability through the loss of the victim, his or her productivity, and the associated disruption caused. Finally, this loss also includes the economic value invested in the victim, the associated death benefits, the loss of anticipated mission contribution, and costs of replacing the victim.

Suicides can be understood and dealt with, and it is likely that a substantial number can be prevented. The ANG "LINK"--adapted from the original HQ AETC/SG program--is designed as a preventive effort which develops a "web" linking individuals, supervisors, first sergeants, commanders, the community, and helping professionals. Together, they create the "concentric circles of concern". Most suicidal individuals want to live, but many are unable to see alternatives to their problem(s). They often view their situation as hopeless. We must "link" people to helping resources and alternatives once we become aware of the need.

Even though mental health intervention is effective and important in these cases, its major shortcoming lies in the fact that the healthcare system can only act if it is aware of the problem. This places the responsibility on individuals to seek help on their own or be referred by others. Sadly, we have fallen short in this area. Two-thirds of the active duty Air Force suicide victims studied from 1983 to 1993 had not come in contact with the healthcare system. To turn this around, buddy care must flourish with early identification and referral of potentially at-risk personnel by those who perhaps know them best—their friends, co-workers, and supervisors. Finally, commanders and first sergeants must act as a gateway to helping resources for their people.

TWO LEVELS OF ANG SUICIDE PREVENTION TRAINING

Level 1-Buddy Care

Emanating from the Air Force Suicide Prevention Integrated Process Team (IPT), awareness training with emphasis on stress and suicide risk factors is now conducted annually at all ADAF and ARC duty

stations, as well as all levels of PME. Base medical squadrons (MDS) provide this training during the annual influenza immunization program; the medium is an informative brochure, *Buddy Care Basics*. The training's purpose is to encourage the early identification and referral of potentially at-risk individuals to supervisors and other helping personnel. Based on local needs and circumstances, MDSs are also encouraged to collaborate with other helping agencies (e.g., chaplains, family support, etc) to develop and implement additional suicide prevention training to augment *Buddy Care Basics*.

Level 2—Commanders and First Sergeants

Chaplains conduct annual refresher training for commanders and first sergeants in the identification and referral of at-risk personnel, squadron-level risk management programs, and managing organizational stress. The purpose of this training is to equip squadron leaders with the tools they need to: identify potentially at-risk personnel under their command; get their at-risk people the help they need; minimize barriers to self-referral faced by their people; and de-stigmatize help-seeking behavior through changing the corporate culture. Mentoring at the commander and first shirt level will assist in this effort, and is a natural complement to the "buddy care" concept encouraged at the individual level (for co-workers and supervisors). Referrals should be made to base or community resources, such as chaplains (or family support center if activated), or civilian community mental health or hospitals (as in the case of emergency referrals of at-risk personnel).

KNOW THE FACTS

1. Suicides can be prevented. Most suicidal persons want to live; they are just unable to see alternatives to their problems. They often view their situation as HOPELESS.
2. Most often, suicidal persons are temporarily overwhelmed with real LIFE EVENTS. Some of the most commonly experienced are relationship difficulties, separation, divorce, financial problems, pending legal or administrative actions, investigation, work problems, loss of a loved one, major illness, etc.
3. Most suicidal persons give definite WARNINGS of their suicidal intentions, but we are often unaware of the significance of these, or do not know how to respond.
4. Suicide cuts across all ranks, ages, and economic, social, religious, and ethnic boundaries.
5. Suicide is the eighth leading cause of death in the US and the third leading cause among 15-24 year-olds, behind accidents and homicide.
6. Males commit suicide at rates and numbers three to four times that of females.
7. Although there are no official US statistics on suicide attempts, it is estimated there are at least 8 to 20 attempts for each death by suicide.
8. Females have been generally found to make three to four times as many attempts as males.
9. Feelings of HOPELESSNESS, such as "there are no solutions to my problem," are found to be more predictive of suicide than a diagnosis of depression per se.
10. The SOCIALLY ISOLATED are generally found to be at high risk for suicide.
11. Again, it is estimated that suicide intimately affects at least six other people.
12. Persons with a mental health diagnosis are generally associated with higher risk of suicide. Groups at particular risk are the depressed, schizophrenics, alcoholics, and those with a panic disorder.
13. Currently, there are over 30,000 suicides annually nationwide (83 per day, one ever 17 minutes), with more than 12 of every 100,000 Americans killing themselves.
14. Firearms are currently the most utilized method of suicide.

15. To reiterate, suicide accounted for 13 percent of all ANG deaths between 1990 and 1997; on average, 13 Air Guardsmen die by suicide each year

BE AWARE OF THE WARNING SIGNS

There is no typical suicidal victim, but there are some common warning signs. When acted upon, a life can be saved. A suicidal person may:

- Talk about committing suicide
- Have trouble eating or sleeping
- Experience drastic changes in behavior
- Withdraw from friends or social activities
- Lose interest in hobbies, work, school, etc
- Make final arrangements, prepare for death
- Give away prized possessions
- Have attempted suicide before
- Take unnecessary risks
- Have had a recent or severe loss
- Be preoccupied with death or dying
- Lose interest in his/her personal appearance
- Increase his or her use of alcohol or drugs

BE AWARE OF FEELINGS

Many persons have had thoughts about suicide at some point in their lives. Most decide to live because they come to realize the crisis is temporary and death isn't. On the other hand, people having a crisis often think their situation is inescapable and feel a sense of hopelessness and loss of control. Some commonly experienced feelings are:

- Can't stop the pain
- Can't think clearly
- Can't make decisions
- Can't see any way out
- Can't get out of depression
- Can't eat, sleep, or work
- Can't make sadness go away
- Can't see a future without pain
- Can't see themselves worthwhile
- Can't seem to get someone's attention
- Can't seem to get control

BE AWARE OF DOs AND DON'Ts

- Do be aware. Learn the warning signs.
- Do get involved. Become available. Show interest and support.
- Do ask if they are thinking about suicide.
- Do talk openly about their suicidal thoughts. Be direct. Determine if they have a plan.
- Do question accessibility to guns, pills, etc.
- Do listen. Allow expression of feelings.
- Do offer empathy, not sympathy.
- Don't lecture or debate. Try not to judge.
- Don't dare them to do it.
- Don't give advice.
- Don't put them off. Take threats seriously.
- Don't act shocked. This will put distance between them and you.
- Don't be sworn to secrecy. Seek support.
- Do offer hope that alternatives are available.
- Do take action. Remove means, if possible.

- Don’t leave them alone. Get help now.

WHO ARE THE “HELPING RESOURCES”?

- Supervisors, First Shirts, Commanders--You
- Chaplains
- Mental Health Professionals
- Security or Local Police
- Family Support/Advocacy Centers
- Legal Professionals
- 911, Hospital ER, Fire Department

Critical Incident Stress Mgmt Teams

WHAT TO DO—LONG TERM

- PROMOTE unit-wide sensitivity to potential risk factors. Unit members should be encouraged to talk to their supervisors, first sergeants, or commanders without fear of retribution when they feel the need.
- BE ALERT to factors that may cause stress in your subordinates. **Take care of your people**.
- KNOW your people. Be aware of changes in their attitude, behaviors, and/or performance.
- IDENTIFY "at-risk" personnel. Be on the lookout for individuals who appear to have problem and get help for them. Don't place those who are determined to be "at-risk" in demanding situations or where they cannot be observed.
- BE CONCERNED about the welfare and morale of your people. If you are aware of personnel experiencing significant life events, show an interest and ask how they are doing frequently and regularly. Don't underestimate the significance of these events.
- COMMUNICATE with your people. STOP moralizing and providing easy solutions. LOOK for nonverbal cues and inconsistency between what is said and what is done. LISTEN for the feelings behind the words—feelings of despair and hopelessness should prompt immediate concern.
- BE AVAILABLE AND SUPPORTIVE. Manage by walking around to get "eyes on" your people and their situation, and to allow them access to you. Act to get help or services for your people and have their supervisor go with them if necessary.

WHAT TO DO—IMMEDIATELY!

If you are concerned about an individual you feel may be at-risk, get help immediately. Don't leave the person alone. Be up front with them; communicate your concerns and what you are doing to get them help. Contact the helping resources available to you and discuss the situation; chaplains are the logical first choice. If it is determined they need an immediate emergency referral to mental health, have a trusted co-worker (perhaps their supervisor), friend, or family member go with them. Besides helping the provider understand the situations and/or behaviors which prompted the referral, it sends a powerful message to your people that you care for them and have a vested interest in their well-being.

If you encounter a suicide in progress, get help immediately through the hospital emergency room or call 911. Remain calm and stay with the individual until help arrives. If the person has a dangerous weapon, don't be a hero. Remember, the suicidal person is emotionally out of control and in these situations your life may also be in danger.

CLUSTERING

One risk factor that has emerged from research on suicide is the suicide "contagion" or cluster effect. This is a process by which exposure to the suicide or suicidal behavior of one or more persons influences others to commit or attempt suicide.

Although this concept is not easily understood, it appears that any given community has a population "at-risk", consisting of people who are more than a casual risk for suicide. Most of these people are perhaps ambivalent about taking their lives. They may think about suicide frequently, but have not committed to a plan to act. However, if another individual does commit suicide, especially if he or she is viewed as someone like himself and herself, this reinforces the idea that suicide is an option. Research

has indicated that the effect of contagion appears to be strongest among younger age groups. If this is true, it is a powerful incentive to be especially mindful of the need for preventive intervention in the wake of a completed suicide. The following suggestions should be considered:

- Inform other unit members of the basic circumstances of the suicide.
- Don't talk directly about the act. Too much detail may serve as a "how to" description.
- Seek the assistance of chaplains and other helping professionals, especially immediately following your initial formal discussion of the event with unit personnel. These professionals should be on scene during this initial period. The object is to afford personnel the chance to ventilate any feeling they might have surrounding this death. It also gives the helping professionals a chance to get an "eyes on" look at individuals who may be more deeply disturbed.
- You may also request, through the Air Force, support from a Critical Incident Stress Management (CISM) Team in your region. It is Air Force policy to provide critical incident stress management preventive services to unit and community members before, as well as after, potentially traumatic events occur. For example, CISM units may be required in support of aircraft or other accidents, unit suicides or homicides, or any other disturbing events. The goal is to assist those affected by traumatic events to cope with the normal stress reaction in an effective manner. These actions are intended to minimize the impact of exposure to these events and prevent or mitigate permanent disability if possible. Reference AFI 44-153, *Critical Incident Stress Management,* for procedures.
- Conduct personal interviews with members of the unit who you feel may be most seriously affected by this event. If it appears they are having difficulty, bring them to the attention of the chaplain or refer them to a mental health professional.
- Don't glorify the suicide victim's positive characteristics. If his or her problems are acknowledged in the presence of laudatory statements, such suicidal behavior may appear attractive to others at risk, especially those who rarely receive positive reinforcement for desirable behaviors.
- Be aware that some characteristics of news coverage of suicide may contribute to the contagion. All parties should understand that a scientific basis exists for concern that news coverage of a suicide may contribute to the cause of other suicides.
- Don't present simplistic explanations. The final precipitating event is rarely the only cause and shouldn't be seen as a tool for accomplishing certain ends. The majority of victims had multiple factors that contributed to their situation. Just acknowledging this without significant detail is helpful.
- Don't engage in repetitive, ongoing discussions of the suicide.

RISK MANAGEMENT

As mentioned previously, no one is immune to being potentially at risk for suicide. There is no typical victim, but we do know victims have experienced life events which they interpreted as being overwhelming or hopeless. Two tools to assist you in your risk management efforts are attached—a Military Life Survey (attachment 1) and an Awareness profile (attachment 2). These tools are provided for your use as deemed appropriate; there is no requirement to use them.

Military Life Survey. This tool should be used to think about potential life event stressors your people might be experiencing. This survey can be duplicated and distributed to all personnel to assist in stress management activities. It can be done at specified intervals, such as semiannually or annually.

The point values are only crude indicators for possible concern and should be followed up with personal engagement with people you are concerned about to determine how they are handling these events. ANG

members scoring under 200 points are more LIKELY to be experiencing good physical and emotional health. Those scoring between 200 and 400 points on this scale should consider enrollment in a stress management program, but are not LIKELY to represent a danger to themselves or others. Members scoring more than 400 points should be STRONGLY encouraged to seek counseling services or at least enter a formal stress management program as soon as possible. Some of these individuals may be at significant risk for accidental self-harm.

Awareness Profile. This awareness tool should be used anytime you become concerned about one of your personnel and his or her potential level of risk. It is recommended that this tool be limited to use by the commander or first sergeant. It is only intended as a device to help you assess potential areas of risk for personnel who are identified to you as possible concerns. Individuals experiencing only a couple of factors should increase your concern level. Supervisors should be more directly involved with these individuals to demonstrate concern through providing assistance, support, and encouragement.

Individuals who seem to be experiencing *multiple* factors should be brought to the attention of the commander, who should discuss the situation with the first sergeant. This discussion should include a review of known concerns and what is being done, and should be done, to assist the individual. Consultation with a mental health provider may be indicated to determine further action.

Note: Individuals who make direct suicidal remarks are judged to be an imminent risk and should be referred to a mental health provider immediately. Do not leave them alone. The commander or first shirt must ensure the individual is escorted by a responsible individual to this appointment.

CONCERNS

How do you talk to someone about your concerns? The following could serve as an outline:

- EVENT: Discuss the events you are aware of that concern you and listen for other potential events. E.g., "I heard about the loss of your mother and was concerned. How are you doing with this?"
- INTERPRETATION AND MEANING: No two individuals interpret events the same way. Events interpreted as being hopeless are often indicative of potential risk. An inquiry should be made to determine how individuals are interpreting these events and the meanings these events have to them.
- THOUGHTS: Frequently, based on their interpretation, individuals have thought about potential actions based on these meanings or beliefs about their situation. Again, asking what they have thought about as a result should be pursued.
- FEELINGS: Many behaviors are preceded by a feeling or emotion, particularly suicide. Again, following this line of conversation, inquire how they have been feeling as a result.
- PLAN: Determine how they plan to handle this situation. If individuals indicate potential suicidal thoughts, the question needs to be asked very clearly, "Have you thought about suicide? Do you have a plan?" Determine also the accessibility to means. Again, if there is any doubt, consult with a mental health provider. If it is after duty hours, contact appropriate helping resources—the hospital emergency room, 911, Security or Local Police, etc. DO NOT LEAVE THIS PERSON ALONE.

Attachments

1. Military Life Survey
2. Awareness Profile

Attachment 1 to Level 2 Brochure: **MILITARY LIFE SURVEY--*Military Life Event***

RANK		*VALUE*
1.	Death of Spouse…	..100
2.	Divorce…	…73
3.	Marital Separation or Remote Tour…	…65
4.	Suicide of a Family Member or Close Friend…	…63
5.	Death of a Close Family Member…	…63
6.	Personal Injury or Illness…	…53
7.	Marriage…	…50
8.	Reduction in Rank…	…47
9.	Marital Reconciliation or Reunion from Long Tour or TDY…	…45
10.	Retirement, Separation, or PCS (desired or not…	…45
11.	Change in Family Member's Health…	…44
12.	Pregnancy (desired or not)…	…40
13.	Significant Emotional Distress, such as Depression, Anxiety, Anger, etc…	…39
14.	Addition to Family…	…39
15.	Frequent TDYs…	…39
16.	Change in Financial Status…	…38
17.	Death of a Close Friend…	…37
18.	Voluntary or Involuntary Cross-Training…	…36
19.	Change in Number of Marital Arguments…	…35
20.	Mortgage or Loan over 50,000…	…31
21.	Harsh Air Force Disciplinary Action…	…30
22.	Change in Work Responsibilities…	…29
23.	Son or Daughter Leaving Home …	…29
24.	Trouble with In-Laws…	…29
25.	Outstanding Personal or Military Achievement…	…28
26.	Spouse Begins or Stops Work…	…26
27.	Starting or Ending Civilian or Military School…	…26
28.	Change in Living Conditions…	…25
29.	Revision of Personal Habits, such as Smoking or Drinking…	…24
30.	Trouble with Chain of Command…	…23
31.	Change in Work Hours or Conditions…	…20
32.	Change in Local Residence…	…20
33.	Change in Schools, Self or Family Member…	…20
34.	Change in Recreational Habits…	…19
35.	Change in Church Activities…	…19
36.	Change in Social Activities…	…18
37.	Mortgage or Loan under 50,000…	…17
38.	Change in Sleeping habits or Quality…	…16
39.	Trouble with Air Force or Civilian Coworkers…	…15
40.	Change in Eating Habits, Gained or Lost Weight…	…15
41.	Annual Leave…	…13
42.	Religious Holiday Season…	…12

43. Minor Air Force Disciplinary Action… …11

Total_____

Attachment 2 to Level 2 Brochure: **AWARENESS PROFILE**

DEMOGRAPHIC FACTORS

AGE:	22-30	----------
GRADE:	Enlisted (E-3 – E-6)	----------
	Officers (0-2 – 0-4)	----------

RISK FACTORS

RELATIONSHIP:	Problems with Intimate Relationships (Marital problems, separation, divorce, breakups)	----------
HISTORY:	Prior Gestures, Attempts, or Allusions (Vague allusions/threats or indirect comments)	----------
EMOTIONAL:	Changes in Mood/Emotional status (Depressed, sad, apathetic, hopeless, irritable, anxious, etc.)	----------
WORK:	Work-Related Problems (Academic problems for tech training students)	----------
SUBSTANCE:	Substance Abuse Problems	----------
FINANCIAL:	Financial Problems	----------
LEGAL:	Legal Problems/Investigation	----------
TREATMENT:	Mental Health/Family Advocacy	----------
DEATH:	Recent or Unresolved Loss of Loved One	----------
HEALTH:	Changes in Physical Health	----------

- ***NOTE:*** **Personnel making direct suicidal remarks or judged to be an imminent risk should be referred to mental health immediately!**

BRIEF EXAMPLE: A 21- year-old-white male, Traditional Guard staff sergeant filled out a Military Life Survey during squadron screening. His survey was had the following life events noted:

Rank	Military Life Event	Value
2	Divorce…	73

3	Remote Tour (upcoming…		65
5	Death of a Close Family Member…		…63
13	Significant Emotional Distress…	…39	
16	Change in Financial Status…		…38
28	Change in Living Conditions…		…25
32	Change in Local Residence…		…20
33	Change in Self…		…20
36	Change in Social Activities…		…18
37	Mortgage or Loan less than 50,000…		…17
38	Change in Sleeping Habits or Quality…		…16
40	Change in Eating Habits …		…15
		TOTAL:	**409**

Due to the person's score, the first sergeant personally engaged him to determine how he was handling these life events, following the previously recommended approach (Event—Meaning—Thoughts—Feelings—Plan):

FIRST SERGEANT: "John, I heard about your recent divorce. How are you handling it?"

JOHN: "Not good, especially due to the financial hardships it has created and the fact that I don't get to see my kids like I used to. I guess since my dad died last month, I don't really have anyone to talk to. This upcoming deployment certainly isn't going to help. I feel so tired; I don't sleep or eat much anymore. I don't feel like this will ever end."

FIRST SERGEANT: "I'm really concerned about you. You mentioned some very significant losses. What do these mean to you?"

JOHN: " I don't see any future for myself. It seems hopeless with all that's on me right now."

FIRST SERGEANT: " You mentioned feeling hopeless and no sense of future. What have you been thinking about lately?"

JOHN: "Actually, all I think about is how unfair life is. What did I do to deserve this?"

FIRST SERGEANT: "How do you feel inside right now?"

JOHN: "I feel sad, depressed; numb, in fact. I don't know if I have any more feelings at all."

FIRST SERGEANT: "What have you thought about doing to deal with all this?"

JOHN: "I feel like ending it all. I would just like to go to sleep and never wake up."

FIRST SERGEANT: "Do you feel like killing yourself?"

JOHN: "Yes. In fact, that's all I think about."

FIRST SERGEANT: "Do you have a plan?"

JOHN: "I bought a gun yesterday. I thought about driving up to the lake, by myself, and then doing it."

FIRST SERGEANT: "John, I don't want you to do that. I am concerned and want to help. I want us to talk to the commander about this. I am sure she would be concerned too. I feel there are some things we can do to help. Will you go with me?"

JOHN: "Yeah, I guess. I just don't know what else to do."

Besides the direct communication of a suicidal intent, we can also see that John is at-risk on the basis of the life events he shared during this conversation, as applied to the Awareness Profile.

RISK FACTOR	
Age	x
Grade	x
Relationship Problem (spouse)	x
Financial Problems	x
Death (father)	x
Health (fatigue, sleep, appetite problems)	x
Emotional (depression)	x

Due to his verbalized suicidal intent, he should be referred to mental health immediately after the consultation with the commander. Even if he had not made a direct suicidal threat, on the basis of the Awareness Profile score, mental health should be consulted for possible referral.

CAUTION: Since individuals process life events differently, we cannot underestimate the significance of a single life event, such as a divorce, investigation, or disciplinary action, combining with other factors already present. We need to talk to these individuals as well as assess how they are coping with their situation. If there are any doubts as to their level of risk, contact a mental health provider. IF A SUICIDAL THREAT IS VERBALIZED, REFER TO A MENTAL HEALTH PROVIDER.

RISK CATEGORIES BASED ON ACTIVE DUTY AIR FORCE SUICIDES, 1983-1993

Data from the OSI study of active duty suicides from 1983-1993 by Dr Charles McDowell, provides useful insight into developing an understanding of the demographics of potentially "at-risk" personnel. We must exercise caution in assuming that these totally represent those possibly at risk. As stated previously, anyone can be at-risk; however, we do know that past suicides have been preceded by life events that were common to many of the victims.

In the years from 1983 to 1993, the Air Force averaged 66 suicides yearly, which means an active duty suicide occurred about once every 5 days. Over this time period, the overall average suicide rate was 11.8 per 100,000 active duty Air Force members compared to 12.2 per 100,000 for the total US population. It must be noted these are gross rates which have not been adjusted for age, sex, or race and there are significant variations within the larger population which make gross rates themselves inadequate as an accurate measure of the problem.

The average age for the Air Force suicide victim was 29, with about 88 percent of the suicides committed by whites, 10 percent by blacks, and 2 percent by other races. OSI data indicates that 89 percent of the total victims were enlisted, with enlisted white males representing 74 percent of this group.

Because of this elevated level of suicide victimization, the category of enlisted white males is commonly referred to as the Air Force's "high risk" population. Males accounted for approximately 94 percent of all suicides during this time period. However, current Air Force data suggest that females attempt suicide at rates three to four times greater than that of males.

For completers of suicide within the Air Force, a gun has been the most common method. From our data on attempters, overdose was the most common method. The majority of attempted, as well as completed, Air Force suicides for 1994 occurred on base.

- Relationship Difficulties. OSI data indicates that fully 76 percent of the victims of suicide from 1983-1993 experienced serious problems in intimate relationships.

- Multiple Problems. Slightly over 60 percent of the victims in this study experienced multiple, serious problems at the time of their death.

- Work-Related Problems. Not surprisingly, 43 percent of the victims had work-related problems. Of those who were married, more than a third had both serious marital and work-related problems. Individuals with histories of unsatisfactory work performance should be of concern, as well as those with histories of difficulty with co-workers. A failure to successfully assimilate one's self into the organizational culture, more specifically with one's co-workers, seems to also be related to potential risk in this area. We know from experience with combat units that group cohesiveness is probably one of the most potent buffers against combat stress. Individuals who are not integrated into the unit, newcomers, and those who socially isolate themselves are not as likely to be afforded the positive benefits of this group support, and hence could be at greater risk. The old saying, "No man is an island," indicates the need we all have for significant others in our lives, especially during "bad times".

- Substance Abuse. At least one third of the victims had been involved with either alcohol (22 percent) or drug abuse (10 percent). Substance abuse cannot be adequately viewed in isolation as a cause, but should be more appropriately thought of as a symptom. For many, it is a form of self-medication, a way to cope with their problems, or an escape.

- Financial Problems. Financial problems were a factor in 23 percent of the suicide victims. Individuals you already know of, as well as those you might potentially refer for financial assistance, should be of concern. They may have other problems which will not be known to you without some further discussion and attention to their situation.

- Mental health Problems. Approximately 23 percent of the victims were under, or had recently been under mental health care at the time of their death. At least 53 percent of the victims gave a clear indication they were depressed at the time of their death, and 13 percent had made a previous suicide

attempt or gesture.

- Legal Problems. OSI data indicated that 16 percent of the victims were involved in difficulties with law enforcement agencies or the courts at their time of death. About half of these were under OSI investigation. Being under investigation for a suspected criminal offense, especially if the crime involves moral turpitude, is extremely stressful. This is compounded by the fact that legal outcomes are difficult to anticipate, and many suspects facing serious legal problems worry about public disgrace and a very real threat to their

careers. These individuals should be afforded access to a helping professional for support and should certainly be an object of your attention for potential risk. An especially vulnerable time for these individuals seems to be once they have been initially notified of the investigation, interviewed, and released. It is advisable that you get "eyes on" these individuals and assess them for potential risk before they are released. Again, if there are any doubts as to the level of risk, solicit the counsel of a mental health provider. Other individuals who should be of concern for review are any individuals currently with UIF's and those with derogatory information in their PIF's.

- Death Related Issues. About 5 percent of the suicides involved a death-related issue, almost always involving the death of someone close to the victim.

- Health Problems. Health problems were a factor in 4 percent of decisions to commit suicide.

Suicide is extremely costly. Each enlisted suicide costs $583K*, plus lost productivity and replacement costs. Suicide costs the Air Force over $30M* per year in dollar costs. Emotional costs are immeasurable, but are arguably the most significant. (*1995 dollars).

The ANG suicide experience parallels that described for the ADAF above. The average annual ANG suicide rate for FY92-96 is 13.0 per 100,000. Suicide accounted for 15 percent of all ANG deaths, the second leading single cause for the period. The average ANG member completing suicide is male, 34 years old, a Traditional Guardsman, and separated/divorced.

MANAGING ORGANIZATIONAL BEHAVIOR

There is an old adage among systems theorists which says, "the system creates its own behavior." Many times, we are angry at our subordinates or our children because of they way they act—their behavior. Oddly enough, in many of these situations, they only do what the system allows them to do or what they feel it expects of them. Given this scenario, few will change until the system requires that they do so. If we are angry at our subordinates' continual lack of responsibility, yet we continue to compensate and take responsibility for them, why should they change.

Applied to an organizational perspective, employees often act in a manner consistent with what they feel their boss expects. As part of the ANG LINK initiative, we talk of "changing the organizational culture" at the squadron level as a means of de-stigmatizing and encouraging help seeking behavior and building a network that supports early identification and referral of potentially at-risk personnel. As a part of that, we must make sure the system itself is not part of the problem, but contributes to positive organizational

behavior. This must begin with leadership. How much difference can leadership really make? The next section will address this.

CONCEPT OF PYGMALION

Pygmalion was a sculptor in Greek mythology who carved a statue of a beautiful woman who subsequently came to life. The notion that one person can transform another, or a manager can transform an entire organization, was the basis for a "classic" article that appeared in the *Harvard Business Review* by J. Sterling Livingston on the application of Pygmalion in the management. Similarly, Robert Merton's

classic 1957 book, Social Theory and Social Structure, discussed the concept of the "self-fulfilling prophecy" and the effect of expectations, or prophecy, on outcome.

The influence of self-fulfilling prophecies and the Pygmalion effect are applicable to the field of organizational behavior, and management researchers and practitioners are slowly realizing the influence of expectations on behavior. Therefore, every manager should understand how the Pygmalion effect works.

In George Bernard Shaw's Pygmalion, Eliza Doolittle explains, "The difference between a lady and a flower girl is not how she behaves, but how she is treated." Some managers treat their subordinates in a way that leads to superior performance, but many unintentionally treat their subordinates in a way that leads to lower performance than they are capable of achieving. Research in this area has revealed:

- What managers expect from their subordinates and the way they treat them largely determines their subordinates' performance and progress. Said another way, as keepers of the system, managers have a powerful effect on creating the behavior of their subordinates.
- A unique characteristic of superior managers is the ability to create high-performance expectations that subordinates fulfill.
- Less effective managers fail to develop similar expectations and, as a consequence, the productivity of subordinates suffers.
- More often than not, subordinates appear to do what they believe they are expected to do.

Unsuccessful personnel have great difficulty maintaining their self-image and self-esteem. In response to low expectations from their supervisors, they typically attempt to avoid further damage to their egos by avoiding situations which might lead to greater failure. Low expectations, when combined with damaged egos and low self-esteem, lead personnel to behave in a manner that increases the probability for failure, thereby becoming a self-fulfilling prophecy and fulfilling their supervisors expectations.

KEYS TO USING THE POWER OF EXPECTATION

- Perhaps **our greatest organizational challenge** is to prevent the under-development, under-utilization, and ineffective management of our most valuable resource--our people.

- A key trait of effective leaders is their own positive self-regard, which seems to exert its force by creating in others a sense of confidence and high expectations. For leaders to be a Pygmalion, they must

acquire knowledge and skills necessary to be confident of their high expectations and make them credible to their employees.

- Some recent research on leadership failures has indicated credibility is lost after two to three failures known to subordinates. Nothing succeeds like success.

Supervisors can't avoid the depressing cycle of events which flow from low expectations merely by guiding or masking their feeling because the message is usually communicated unintentionally, without conscious action on their part. Managers often communicate most when they think they are communicating the least.

- Critical to the communication of expectations is not so much what managers say, but what they do. The silent treatment, or indifferent and noncommittal treatment, more often than not communicates low expectations and leads to poor performance.

- Managers are often more effective in clearly communicating low expectations than high ones, even though they believe the opposite. Positive feelings usually do not come through clearly enough.

- Superior managers seem to have greater confidence in their own ability to select, train, and motivate their subordinates, and they don't easily give up on themselves or their subordinates.

- The way managers treat, not organize, subordinates is the key to high expectations and productivity.

- Subordinates will not strive for high levels of productivity unless they feel the boss' high expectations are realistic and achievable. In fact, research has indicated that the relationship of motivation to expectancy of success varies in the form of a bell-shaped curve. The degree of motivation and effort rises until their expectancy of success reaches 50 percent, then begins to fall even though the expectancy of success continues to increase. No motivation or response is aroused when the goal is perceived as virtually certain or virtually impossible to attain. Secondly, if subordinates failed to reach performance expectations that are close to their own level of aspirations, they will lower personal performance goals and standards, leading to decreased performance and development of negative attitudes.

- Managerial expectations have their strongest influence on younger personnel because, as personnel mature and gain experience, they tend to see themselves as their career record (or the reality of their past performance) implies.

- The first year is a critical period for learning and a time when the new trainee is uniquely ready to develop or change in the direction of corporate expectations. This leads to the internalization of positive job attitudes and high standards, and these lead to and are reinforced by strong performance and behavior in later years.

- A new trainee's first boss is likely to be the most influential in his or her career. If these supervisors are unable or unwilling to develop the skills younger personnel need to perform effectively, they will set

lower standards than these personnel are capable of achieving. Since these trainees feel their abilities are not being developed or used, this can lead to impaired self-image, lackluster performance, and negative attitudes toward their job and possibly their own career in the Air Force.

- With few exceptions, the first-line supervisors these personnel are paired with are often the least experienced and at times the least effective in the organization. If our initial corporate expectations for performance mold subsequent expectations and behavior, the initial supervisors of new personnel must be the best we have. These supervisors or managers must be willing and able to facilitate the training, education, and development of these individuals.

- Rosenthal and Jacobson (1968) in their book, Pygmalion in the Classroom, identified four factors which positively influence the results of followers:

  - ♦ Successful leaders are able to promote the development of a warm, supportive, and accepting climate. Leaders stimulate high performance by frequent and specific feedback which focuses on what the follower is doing right. The goal of this feedback is to help the follower develop more competence and self-confidence.

  - ♦ Successful leaders provide all the necessary resources to enhance the skills of the followers and allow them to effectively complete tasks.

  - ♦ Leaders should support the attempts by followers by promoting innovative and creative approaches, accepting mistakes during experimentation, and providing assistance in problem-solving.

  - ♦ The importance of managerial expectation permeate the entire military organizational life cycle, beginning with recruitment, during basic training, and continuing until the relationship is terminated through separation or retirement. The impact is **never** more critical than during the training, education, and development process our members undergo.

Organizational leaders must understand and acknowledge the impact of their expectations on the behavior and performance of organizational members and the organizational environment or system these expectations create. Or, as Eliza Doolittle might say, *" The only difference between a high performing organization and a low performing organization is not in the behavior of the members, but how they are treated."*

ANG SUICIDE PREVENTION "*LINK*"

Look for possible concerns
Inquire about concerns
Note level of concern
Know referral resources and strategies

Brochure OPR: ANG/HC (1 Feb 98 version)
3500 Fetchet Ave
Andrews AFB, MD 20762-5157

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Attachment 6

Military Education and Training

Purpose. Desired learning outcomes, suicide prevention; level and depth of curricula depend upon the target audience.

A6.1. Know basic information about how much of a problem suicide is for the Total/Air Force.

A6.2. Know that suicide represents a failure to find other more effective ways to cope with problems that seem insoluble.

A6.3. Know the warning signs of suicide and decreased or impaired emotional status.

A6.4. Know what to say to and do for a subordinate, co-worker, friend, or family member who seems deeply troubled or suicidal.

A6.4.1. Know importance of social support.

A6.4.2. Know relationship of marital problems to suicide.

A6.4.3. Know relationship of suicide to investigations and legal problems.

A6.5. Know where and how to get help.

A6.5.1. Know implications of getting help from a chaplain.

A6.5.2. Know the implications of being seen by a mental health provider.

A6.5.3. Know implications of getting help from off-base sources.

A6.5.4. Know implications of getting help from a friend.

A6.5.5. Know implications of <u>not</u> getting help at all.

A6.6. Know what to do for your unit following a suicide.

Attachment 7

CSAF Message on Air Force Suicide Prevention

151937Z OCT 96 UNCLAS
SUBJECT: SUICIDE
1. SUICIDE AFFECTS THE TOTAL FORCE AND CAUSES THE LOSS OF OUR MOST VALUABLE RESOURCE, TRAINED PROFESSIONALS. IT IS THE SECOND LEADING CAUSE OF DEATH AMONG ACTIVE DUTY MEMBERS. AS LEADERS, WE MUST TAKE ACTION TO TURN THE TIDE ON THE NEEDLESS TRAGEDY OF SUICIDE.

2. INDIVIDUALS WHO COMMIT SUICIDE ALMOST ALWAYS EXHIBIT SIGNS OF DYSFUNCTION, DEPRESSION OR DESPERATION BEFORE THE ACTUAL ACT OF SUICIDE. THESE BEHAVIORAL WARNING SIGNS ARE VARIED AND CAN INCLUDE: A. SIGNIFICANT MARITAL OR PERSONAL PROBLEMS; B. UNEXPLAINED MOOD CHANGES OR DEPRESSION; C. DECLINE IN JOB PERFORMANCE OR PERSONAL APPEARANCE; D. CHANGES IN APPETITIE OR SLEEP PATTERN; E. SOCIAL WITHDRAWAL OR ISOLATION; F. INCREASED USE OF ALCOHOL; G. UNUSUAL INTEREST IN DEATH; H. STATEMENTS ABOUT SUICIDAL THOUGHTS, INTENTIONS OR PLANS; I. GIVING AWAY POSSESSIONS OR SUDDENLY WRITING AN UNEXPLAINED WILL.

3. AS COMMANDERS, FIRST SERGEANTS, AND SUPERVISORS I ASK YOU TO BE ALERT TO CHANGES IN YOUR PEOPLE (BOTH MILITARY AND CIVILIAN) AND CHALLENGE YOU TO LEARN ABOUT THE SUPPORT AGENCIES AVAILABLE TO HELP THEM. THIS WHAT I EXPECT YOU TO DO: A. IF YOUR PEOPLE ARE HAVING SIGNIFICANT FAMILY OR PERSONAL PROBLEMS, TALK TO THEM ABOUT THEIR PROBLEMS. GET THEM TO THE CHAPLAIN, FAMILY SUPPORT CENTER, OR MENTAL HEALTH CENTER. DON'T JUST RECOMMEND THEY GO, DO EVERYTHING IN YOUR POWER TO GET THEM THERE; B. IF THEY HAVE ALCOHOL PROBLEMS, REFER THEM TO A SUBSTANCE ABUSE COUNSELOR. DON'T WAIT UNTIL THERE IS A DUI OR SOME OTHER NEGATIVE INCIDENT; C. IF THEY ARE CONSTANTLY DEPRESSED, MAKE SURE THEY SEE A MEDICAL OFFICER OR MENTAL HEALTH SPECIALIST. FAMILY SUPPORT CENTERS CAN IDENTIFY OFF-BASE MENTAL HEALTH RESOURCES FOR CIVILIANS. D. IF THEY HAVE SEVERE FINANCIAL PROBLEMS, GET THEM TO THE FAMILY SUPPORT CENTER FOR FINANCIAL COUNSELING; E. IF THEY ARE HAVING LEGAL PROBLEMS, GET THEM TO LEGAL SERVICES; F. INDIVIDUALS WHO ARE CHARGED WITH UCMJ VIOLATIONS OR BEING INVESTIGATED FOR OTHER REASONS OFTEN FEEL ISOLATED FROM THEIR CO-WORKERS. THIS GROUP OF INDIVIUALS HAVE SHOWN TO HAVE A HIGHER RISK FOR SUICIDE. BE ALERT TO THIS SITUATION, ASSESS THE WELL-BEING OF THE INDIVIDUAL AND MAKE REFERRALS FOR COUNSELING AS NECESSARY.

4. I WANT THE AIR FORCE TO BE A RESPONSIVE, CARING AND RESPONSIBLE COMMUNITY WHERE INDIVIDUALS ARE MOTIVATED TO SEEK HELP WITH PERSONAL STRUGGLES AND CAN DO SO WITHOUT FEAR OF STIGMATIZATION. ALL OF US IN THE AIR FORCE COMMUNITY MUST PAY ATTENTION TO THE WARNING SIGNS AND OPEN THE DOORS FOR THOSE WHO NEED HELP.

- GEN RONALD R. FOGLEMAN

Attachment 8

Investigative Interview Policy

MEMORANDUM FOR AF/DP SAF/IG SAF/PA 4 December 1996
AF/SP AF/CCC

FROM: CSAF

SUBJECT: Policy for Investigative Interviews

Suicide is the second leading cause of death among active duty Air Force members. A review of Air Force suicides revealed that over 30 percent of those who completed suicide had some type of legal problem. For a variety of reasons, people who have legal problems, or are otherwise under investigation, may feel socially isolated at the very time they need support the most. This policy memorandum establishes responsibilities shared by investigative agencies and unit leaders, and outlines procedures to help ensure the safety and well-being of our most valuable resource, our people. It is not intended to create any right, privilege, or benefit not otherwise required by law. The aim is to ensure individuals at risk get the help they need to successfully cope with their life events, whether that help comes from chaplains, mental health professionals. family support, the legal community, concerned individuals in the unit, or others.

Effective immediately, following initial interviews with Air Force personnel who are the subject of an investigation, Air Force investigators, whether from the Inspector General, Equal Opportunity and Treatment, Equal Employment Opportunity, Security Police, or Office of Special Investigations, will refer the individual to his or her first sergeant, commander, or supervisor. These referrals must include person-to-person contact between the agency and unit personnel, and be documented.

If the individual appears to be emotional, distraught, or stunned during the process of <u>any</u> interview, the interviewee should not be allowed to depart alone, but should be released to his or her first sergeant, commander, supervisor, or their designee, who will help ensure the individual receives the necessary support to safely handle his or her personal crisis. Where a suspected member invokes his Article 31 rights during an interview, the commander, first sergeant, or supervisor will be informed of this fact and instructed to avoid any questioning, interrogation, or discussions in the member's presence of a nature likely to elicit statements or admissions regarding the alleged offense(s). If the member informs investigators that he has already obtained an attorney, it is advisable to also notify the attorney. For agencies that do not have legal authority to detain individuals, a reasonable effort must be made to "hand-off" the individual directly to his or her squadron representative. When a direct hand-off is not possible, a referral as specified above must be made as soon as possible.

Our responsibility to "take care of our own" does not end when an Air Force person, whether active duty, civilian, or member of the Air Reserve Component, comes under investigation. All affected agencies will implement this policy immediately and reflect it in appropriate Air Force Instructions as soon as possible.

//signed//
RONALD R. FOGLEMAN

General, USAF
Chief of Staff

Attachment 9

Limited Privilege Policy

- On 1 Mar 97, AFI 44-109, Mental Health and Military Law, was officially modified to include the Limited Privilege Suicide Prevention (LPSP) Program.

  -- Statistics revealed that ~30 percent of AF members who commit suicide are undergoing or have recently undergone disciplinary action (court-martial or non-judicial punishment).

    --- Disciplinary action may have been "straw that broke the camel's back"; mental health intervention at this critical stage may prevent suicide; lack of confidentiality may have prevented members from seeking help during crises.

  -- Objective of LPSP program: identify and treat those members, who, because of the stress of impending disciplinary action under the Uniform Code of Military Justice, pose a genuine risk of suicide. In order to encourage and facilitate treatment, the LPSP program provides limited confidentiality under the enumerated circumstances.

    --- Only applies after preferral of charges or notification of intent to impose NJP
    --- If individual officially involved in processing disciplinary action (defense counsel, trial counsel, law enforcement official, first sergeant, etc.) suspects member presents risk of suicide, such concern is communicated to member's immediate commander with a recommendation that the individual be placed in the LPSP program
    --- After consultation with a mental health provider, the commander may refer the member for a mental health evaluation
      ---- If the mental health evaluation results in a determination that the member poses a risk of suicide, the member is enrolled in the program and treatment is initiated
    --- Any information revealed in, or generated by the clinical relationship may not be used in any existing or future UCMJ action or when weighing characterization of service in a separation
      ---- The information can be used for any other official purpose
    --- Member disenrolled when no longer a suicide threat; medical records thus annotated
      ---- Information generated after disenrollment is not protected

  -- LPSP program should have no impact on ability to prosecute ongoing cases
    --- Unlikely that post-preferral information will be developed that is critical to a case

- LPSP program is not a result of 13 Jun 96 *Jaffee v. Redmond* decision

  -- *Jaffee* recognized a psychotherapist-patient privilege in federal court cases

  -- Joint Service Committee (JSC) determined *Jaffee* did not automatically apply to military practice; inconsistent with military rule expressly failing to recognize physician-patient privilege

(taken from the original Jan 97 document by JAJM)